Pediatric Nutrition Assessment Form

Name of Child__________________________ Birth Date_____________ Age_________
Name of Parents____
Address ____
Telephone numbers __________________________ E-mail _________________________
Pediatrician ____
Health Insurance ____
Referred by ____
Today's Date ________________

What concerns do you have about your child's diet?

How can I help you and your child? What kind of information and support are you looking for?

Describe your child's physical activity

How much time does your child spend outside per day?
How many minutes per day is your child sitting in front of a screen?
How many hours of sleep does your child get?

Does your child experience constipation, diarrhea, loose stool, heart burn, gas, or bloating? Difficulty swallowing?

List foods that your child is allergic or digestively sensitive to and their reaction:

Height ________ Current weight ________

List all medications, vitamin, mineral, and herbal supplements that he/she is taking:
_________________________ _______________________ _________________________
_________________________ _______________________ _________________________
_________________________ _______________________ _________________________

Describe your child's health history and approximate date of diagnosis:
_____________________________________ ___________________________________
_____________________________________ ___________________________________
_____________________________________ ___________________________________

List significant diseases in your child's family's health history:

______________________________________ ______________________________________

______________________________________ ______________________________________

How would you describe your child's appetite?

Are there any foods or textures that your child dislikes?

As a family, how often do you eat out and where?

Please request your child's growth chart to be faxed to my office at 603-766-1966